Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations, created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully. State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. This Notice remains in effect until it is amended or replaced by us. It is our right to change our privacy practices, provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes to our privacy practices and the terms of our Notice, effective for all health information maintained, created and/or received by us, before the date changes were made. You may request a copy of our Privacy Notice, at any time; by contacting our office. Information on contacting the office can be found at the end of this Notice.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information under routine and certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. **Treatment-** We must use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards ,that limit various staff members' access to your health information, according to their primary job functions. Everyone on our staff is required to sign a confidentiality agreement.
2. **Healthcare Operations-** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you, may also be disclosed to your family, friends and/or other persons you choose to involve in your care, **only if you agree, either verbally or in writing, that we may do so.**
3. **Emergencies-** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only the information directly relevant to your care. We will also use our professional judgment to make reasonable inferences to your best interest, by allowing someone to pick up filled prescriptions, x rays, or other similar forms of health information and/or supplies, unless you have advised us otherwise.
4. **Marketing Health-Related Services-** We will not use your health information for marketing purposes, unless we have your written authorization to do so.

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5. **Public Health Responsibilities-** We will disclose your health information to public health authorities and health oversight agencies, that are authorized by law to collect information, report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
6. **Required by Law-** We may use or disclose your health information, when we are required to do so by law or by a law enforcement officials (court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate of correctional institutions or otherwise under the custody of law enforcement officials.
7. **National Security-** If you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
8. **Abuse or Neglect-** We may disclose your health information to appropriate authorities, if we reasonably believe, that you are a possible victim of abuse, neglect, domestic violence or the victim of other crimes. The disclosure will be only to the extent necessary, to prevent a serious threat to your health or safety or that of others or the public. We will only make disclosures to a person or organization able to help prevent the threat.
9. **Workers comp-** We may disclose your healthcare information to Workers Compensation and similar programs.
10. **Payment-** We may use and disclose your health information to seek payment for services we provide to you, for services already rendered or regarding payment disputes. You hereby agree that the practice may release your information to insurance companies or other financial institutions (e.g. credit card companies, financing institutions or banks) which you may use in order to receive services from the practice, if the practice needs to secure payment for such services or if any payment disputes arise, between you and the practice. This disclosure involves our business office staff and may include insurance organizations or other businesses, that may become involved in the process of mailing statements and/or collecting unpaid balances.

PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial institutions, credit card entities, banks, and financing companies, when requested, to facilitate payment for services provided to you by the practice. Services that are performed and are paid with a credit card, debit card, or financing third party are **NOT** eligible for payment challenges, after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Ziakas to use and disclose my protected health information to any credit card entity, bank, or financing company or institution, when they request such information to process an account and assist with payment for services provided by the practice.
I will not challenge such credit, debit, or financing card payments, once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.
I agree that this non credit card challenge agreement is **irrevocable.**

Your rights regarding your health information

1. **Communications-** You can request that our practice communicate with you regarding your health and related issues, in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work.

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We will accommodate reasonable requests. We may use or disclose your health information, to provide you with appointment reminders, including, but not limited to, voice messages, text messages, emails, postcards or letters.

2. **Restrictions-** You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you may have the right to request that we restrict our disclosure of your health information to only certain individuals, involved in your care or the payment for your care, such as family members or friends. We are not required to agree to your request. Please contact our office if you want to further restrict access to your health care information. This request must be submitted in **writing.** However, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Access-** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You may also request a copy of the health information of an individual, for whom you are a legal guardian. You must submit your request **in writing** to our office. Copies, if requested, **will incur copying costs**, in accordance to state law. If you want the copies mailed to you, **postage will be charged**.
4. **Amendment-** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete, and as long as the information is kept by or for our practice. Your request **must be in writing** and **must include an explanation and/or documentation** of why the information should be amended. Under certain circumstances, your request may be denied.
5. **Right to a copy of this notice-** You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice by contacting our front desk receptionist.
6. **Right to file a complaint-** If you feel we have not complied with our Privacy Policies or if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our front office. Complaints must be submitted **in writing**. You will not be penalized or retaliated upon for filing a complaint.
7. **Right to provide an authorization for other uses and disclosures-** You have the right to receive a list of non-routine disclosures, we have made of your healthcare information. (When we make a routine disclosure of your information, to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have a right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our front office.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices of New Body Plastic Surgery, P. A.

Patient Name:_____________________________________Signature:____________________________Date:_______________________________

Witness Name:_____________________________________Signature:____________________________Date:______________________________

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